

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16106

FILED MAY 31 1951

BIRTH NO. 7183-51 REG. DIST. NO. 6 PRIMARY REG. DIST. NO. 5424 Registrar's No. 128

1350

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Dunklin | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dunklin | |
| b. CITY (If outside corporate limits, write RURAL and give township) Rural-Union Twp | | c. CITY (If outside corporate limits, write RURAL and give township) Rural-Union Twp. 0350 | |
| c. LENGTH OF STAY (In this place) Life | | d. STREET ADDRESS (If rural, give location) Rte 2 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Home | | | |

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|-------------------------------------------------------------------|--|-------------|-----------------------------------------------------------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) LAVERN MANSFIELD | | | 4. DATE OF DEATH (Month) (Day) (Year) May 18, 1951 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |

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|-------------------------|--|----------------------------------|--|-------------------------------------------------------------------------|--|-----------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------|--|
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant | | 8. DATE OF BIRTH Feb. 3, 1951 | | 9. AGE (In years last birthday) 3 Months 15 Days | | IF UNDER 1 YEAR Hours Min. | |
|-------------------------|--|----------------------------------|--|-------------------------------------------------------------------------|--|-----------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Campbell, Missouri 0 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
|--------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|--------------------------------------------------------------------------|--|-----------------------------------------------|--|

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|-----------------------------------------------|--|--------------------------------------------------|--|------------------------------------------|--|
| 13a. FATHER'S NAME Claude Mansfield | | 13b. MOTHER'S MAIDEN NAME LUIZA HEFNER | | 14. NAME OF HUSBAND OR WIFE -- | |
|-----------------------------------------------|--|--------------------------------------------------|--|------------------------------------------|--|

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|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|-----------------------------------------------------------------------------|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT'S SIGNATURE OR NAME Irene Rainey, Campbell, Mo. R.1 | | ADDRESS | |
|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|-----------------------------------------------------------------------------|--|---------|--|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hydrocephalus | | | | | |
| | | DUE TO (c) | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 752x | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|-------------------------------------------------|--|--|--|--------------------------------------------------------------------------|--|

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|------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
|------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|

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|-------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|-------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------|--|

22. I hereby certify that I attended the deceased from **May 17, 1951**, to **May 18, 1951**, that I last saw the deceased alive on **May 17, 1951**, and that death occurred at **10:40 AM**, from the causes and on the date stated above.

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|--------------------------------------|--|-------------------|--|--------------------------------------|--|------------------------------------|--|
| 23a. SIGNATURE [Signature] | | (Degree of title) | | 23b. ADDRESS Campbell, Mo. | | 23c. DATE SIGNED 5/18/51 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE May 19, 1951 | | 24c. NAME OF CEMETERY OR CREMATORY Elder Cemetery | | 24d. LOCATION (City, town, or county) (State) Campbell, Mo. R.2 | |
|------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------|--|---------------------------------------------------------------------------|--|

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|--------------------------------------------|--|---------------------------------------------|--|-----------------------------------------------------------------------------|--|---------------------------------|--|
| DATE REC'D BY LOCAL REG. 5/19/51 | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE Friends And Landess Funeral Home | | ADDRESS Campbell, Mo. | |
|--------------------------------------------|--|---------------------------------------------|--|-----------------------------------------------------------------------------|--|---------------------------------|--|

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 5-21-51

COUNTY FILE NUMBER 551-141

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Not Embalmed

Signed.....

Student Embalmer

Licensed Embalmer No.

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.